

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

01565

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH:

County..... Cecil
 City or town..... Port Deposit
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil
 City or town..... Port Deposit
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Ernest Baker

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... Myrtle Dorcus Baker
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... January 23, 1887
 8. AGE: Years..... 61 Months..... 0 Days..... 23 If less than one day..... hrs. min.

9. Birthplace..... Port Deposit, Cecil Co., Md.
 (Town, county, and state)
 10. Usual occupation..... Merchant
 11. Industry or business..... General Store
 12. Name..... William H. Baker
 13. Birthplace..... Md.
 14. Maiden name..... Leah Jackson Baker
 15. Birthplace..... Cecil Co., Md.

16. Informant..... Myrtle D. Baker
 Address..... Port Deposit, Md.
 17. Burial..... Date thereof..... Feb. 8, 1948
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)
 Cemetery or crematory..... Hopewell
 Location..... Port Deposit, Md. Rural
 18. Funeral director..... L. A. Patterson & Son
 Address..... Perryville, Md.

19. Feb. 8, 1948.....
 (Date rec'd by registrar).....
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 2/5 1948 at 10:45 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Feb 5 1948 and that I last saw him alive on Feb 5 1948

Immediate cause of death..... Coronary Arteriosclerosis
 Accident.

Due to..... Arteriosclerosis
 Due to..... Diab. H's

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address..... B. + D. 55. + L. Date signed..... 2-7-48
 M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information or fact. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

01566

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil
 County.....
 City or town..... ELKTON
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
UNION HOSPITAL
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... MARYLAND County..... Cecil
 City or town..... ELKTON RD #2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ELK SIDE #7
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Britten.

3. (b) Social Security Number

4. Sex..... MALE
 5. Color or race..... WHITE
 6. (a) Single, married, widowed, or divorced..... SINGLE
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... 18 February 1948
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min. 6 8

9. Birthplace..... ELKTON, Cecil, MARYLAND
 (Town, county, and state)
 10. Usual occupation..... INFANT
 11. Industry or business.....

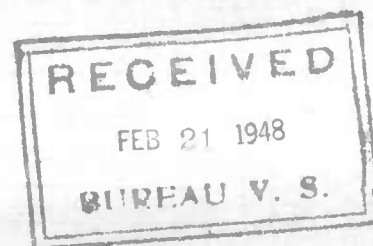
12. Name..... Herbert Britten
 13. Birthplace..... WASHINGTON, D.C.
 14. Maiden name..... RUTH KOCH
 15. Birthplace..... BALTIMORE, MD.
 16. Informant..... HOSPITAL RECORDS.
 Address..... Elkton, Md
 17. Buried Date thereof..... Feb 19 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Elkton Cemetery
 Location..... Elkton Md
 18. Funeral director..... H. W. Pippin
 Address..... Elkton Md
 19. Feb 19 19 48 J. F. Frague
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 18 19 48 at 6:15 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18 19 48 to Feb 18 19 48 and that I last saw him alive on Feb 18 19 48
 Immediate cause of death..... Remained by
 DURATION.....
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE..... Dr. H. W. Pippin M.D.
 Address..... Elkton, Md Date signed..... Feb 18 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... Cecil
City or town... Elberton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

Black

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Kenna Clark

7. Birth date of

deceased (mo., day, yr.)

7-3-1968

8. AGE:

Years

79

Months

6

Days

If less than one day

hrs.

min.

9. Birthplace

Port Deposit, Cecil co. Md.

10. Usual occupation

Laborer

11. Industry or business

Samuel Clark

12. Name

Port Deposit, Md.

13. Birthplace

Ashira Chambers

14. Maiden name

Port Deposit, Md.

15. Birthplace

George A. Clark

16. Informant

Port Deposit, Md. R.H.

Address

Burial

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Feb 6 1948

Cemetery or crematory

Cokebury

Location

Port Deposit, Md. and

R. A. Patterson & Son

18. Funeral director

Cerrville, Md.

Address

Feb 3 1948

19. (Date rec'd by registrar)

F. H. Frazier

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Cecil

City or town... Port Deposit
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb 3rd 1948 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 2 1948 to Feb 3 1948

and that I last saw him alive on Feb 3 1948

Immediate cause of death... Cerebral hemorrhage

DURATION

20 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE

Elberton Md

M. D. or other

Address... Date signed 2/3/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
City or town ELKTON
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 WK.
Hospital, institution, or street address where death occurred:
UNION HOSPITAL
How long in hospital or institution? 1 WK.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MARYLAND County CECIL
City or town RISING SUN
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

DENMAN GARRISON

3. (b) Social Security Number

214-01-8997

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE WHITE MARRIED

8. (b) Name of husband or wife CLARA GARRISON

8. (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 2 FEBRUARY 1874

8. AGE: Years Months Days If less than one day
74 - 8 hrs. min.

9. Birthplace New Jersey
(Town, county, and state)

10. Usual occupation UNEMPLOYED

11. Industry or business

12. Name UNKNOWN

13. Birthplace

14. Maiden name UNKNOWN

15. Birthplace

16. Informant HOSPITAL RECORDS

Address Elkton Md.

17. Burial Date thereof 2-13-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brookview Cemetery

Location Rising Sun, Md.

18. Funeral director Ralph M. Reed

Address Rising Sun, Md.

19. Feb 12 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 FEBRUARY 1948 at 9 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1948 to Feb 10 1948 and that I last saw him alive on Feb 10 1948

Immediate cause of death _____ DURATION

Coronary
of Arteries

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. P. Dockery M. D. or other
Rising Sun Md. Date signed 2/11/48

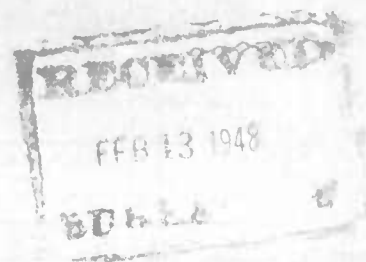
MARGIN RESERVED FOR BINDING

VS A15 9-25-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly

01568

468



7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County CECIL
 City or town PERRY POINT, MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 years 9 months
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Maryland
 How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State KANSAS County Sedgwick
 City or town Wichita
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 616 1/2 North Emporia
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW-I

3. (a) FULL NAME

LAWRENCE W. GREEN

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
6. (b) Name of husband or wife <u>---</u>		
7. Birth date of deceased (mo., day, yr.) <u>February 16, 1884</u>		
8. AGE: Years <u>63</u>	Months <u>11</u>	Days <u>23</u>
If less than one dayhrs.min.		

9. Birthplace Kansas
 (Town, county, and state)
 10. Usual occupation Telephone Operator
 11. Industry or business

12. Name William Melvin Green
 13. Birthplace Unknown
 14. Maiden name Alice Ransom
 15. Birthplace Unknown

16. Informant Hospital Records
 Address VAH, Perry Point, Md.

17. Removal Date thereof 2-12-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
 Location Baltimore, Maryland

18. Funeral director James E. Dougherty
 Address Havre de Grace, Maryland

19. Feb. 12 19 48 James E. Dougherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9th 19 48 at 1:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 30th 19 39, to Feb. 9 19 48
 and that I last saw him alive on Feb. 9th 19 48

Immediate cause of death Heart Failure DURATION 3 hrs.

Due to Generalized arteriosclerosis Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE A. E. TROLLINGER, M.D., Chf. Prof. Serv.

VAH, Perry Point, Md. M. D. or other

Address Date signed 2/12/48

RECEIVED
FEB 14 1948
U. S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1952

01570

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH:

County Sevier
 City or town Ellettsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 hours
 Hospital, institution, or street address where death occurred:
Union Hospital
 How long in hospital or institution? 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind County Sevier
 City or town Ellettsville Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Norma Jean Harris

3. (b) Social Security Number

4. Sex F 5. Color or race White 6. (a) Single married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 19 1947
 6. (c) If alive, give age _____ years

8. AGE: Years 3 Months 21 Days _____ If less than one day _____ hrs. _____ min.

8. Birthplace Ellettsville Ind
 (Town, county, and state)

10. Usual occupation child

11. Industry or business

12. Name Henry Harris

13. Birthplace North East Ind

14. Maiden name Ida May Painter

15. Birthplace Perrine Sun Ind

16. Informant Health Dept Records

Address Ellettsville Ind

17. Burial Date thereof 2-10-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist

Location North East Ind

18. Funeral director Joseph R. Crane

Address North East Ind

19. Feb 10 1948 FR Frazer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1948 at 7 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ on _____ 19 _____

Immediate cause of death Malnutrition

Underlying cause: Neglect & poor care [4/1/48 a b c]

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Medical Examiner _____

23. SIGNATURE R. E. Dockson M.D. _____

Address Perrine Sun Ind _____ M. D. or other _____

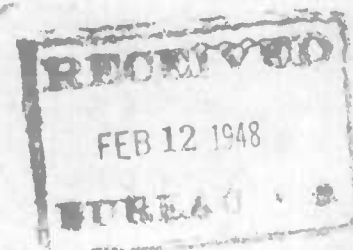
Date signed 2/10-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01571

Reg. Dist. No. 96

1. PLACE OF DEATH:

County.....
City or town.....
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State.....
County.....
City or town.....
Street No.....
2. (a) If veteran, name war.....

3. (a) FULL NAME

Belle Hollingsworth

3. (b) Social Security Number

4. Sex.....
5. Color or race.....
6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years..... Months..... Days..... It less than one day..... hrs. min.

9. Birthplace.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Cremation.....

17. (Burial, cremation, or removal. Which?).....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar).....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

and that I last saw him/her alive on.....

Immediate cause of death.....

Other conditions.....

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur?.....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

Address.....

Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 21 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of
birthplace shown on:

FILE No. G 115 MAY 12 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... Cecil
City or town... Elberton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 hrs
Hospital, institution, or street address where death occurred:
Union Hosp.
How long in hospital or institution? 10 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Md County... Cecil
City or town... Coopersville - Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Norma Jamison

3. (b) Social Security Number

4. Sex... Female 5. Color or race... Black 6. (a) Single, married, widowed, or divorced... Married
(b) Name of husband or wife... Charles James Jamison
6. (c) If alive, give age... 30 years
7. Birth date of deceased (mo., day, yr.)... April 30, 1921
8. AGE: Years... 26 Months... 9 Days... 2 If less than one day... hrs. ... min.

9. Birthplace... John Hopkins Hosp., Baltimore, Maryland
(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

12. Name... Fred Alexander
13. Birthplace... Cecil Co Md
14. Maiden name... Alice Simson
15. Birthplace... Baltimore Md.

16. Informant... Mrs Charles Jamison
Address... Forest Hill Md.

17. Burial Date thereof... Feb 3 48
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory... Fairview
Location... Forest Hill Md.

18. Funeral director... Charles C. Kurtz
Address... Garretttsville Md.

19. Feb 1 19 48 FR Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb 1 1948 4:35 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 31 1948 to Feb 1 1948
and that I last saw her alive on Feb 1 1948

Immediate cause of death... Starvation & dehydration about 3 weeks

Due to... An acute mental derangement same

Due to...
Other conditions...

(Include pregnancy within 3 months of death)

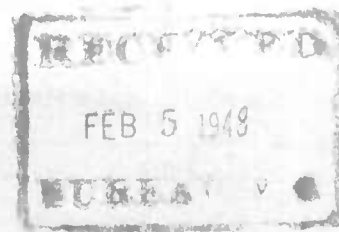
Major findings of operations... Date of op.

Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of ...
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE... V. H. McKnight
Address... Elberton Md Date signed 2/1/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age in birth date and age is shown on is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for changes in birth date and age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

01574

94

FILM No. G 114 MAR 1 1948 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Cecil
 City or town..... North East Md. rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 North East Md Rd
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Md. County..... Cecil
 City or town..... North East rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Henry Thomas Kinslow

3. (b) Social Security Number

Unknown

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

Col.

Married

6. (b) Name of husband or wife

Margaret Kinslow

7. Birth date of deceased (mo., day, yr.)

Feb. 17, 1870 B. (c) If alive, give age..... years

8. AGE:

79 78

Months

3

Days

29

If less than one day

..... hrs. min.

9. Birthplace

Md.
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER MOTHER

12. Name

Aron Kinslow

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

If

16. Informant

Joseph W. Kinslow
Address North East Md.

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof..... 2/22/48
(month) (day) (year)

Cemetery or crematory

Zion Cemetery

Location

rural North East Md.

18. Funeral director

Edward R. Bell

Address

909 Poplar St. Wilming. Del.

19.

Feb 22 1948 L. A. & C. Owens
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1948 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 10 1948 to February 17 1948
and that I last saw him alive on February 14 1948

Immediate cause of death

Heart insufficiency

DURATION

54 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James D. Johnson M.D.

M. D. or other

Address

Edenton, Md.

Date signed 2/19/48

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. Name of deceased

2. Date of death

3. Place of death

RECEIVED

FEB 26 1948

BUREAU V. S.

CERTIFICATE OF DEATH 165

Registered No. 01575

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Harford Avenue(c) Hospital or institution: Perryville, Cecil, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Cecil(c) City or town Perryville
(If outside city or town limits, write RURAL and give town)(d) Street No. Harford Avenue
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 19488. AGE: Years Months Days If less than one day
hr. (?) 5 min.9. Birthplace Harford Ave., Perryville, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof 3-1-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Port Deposit Burial Ground18 (a) Funeral director W. A. Patterson & Son(b) Address Perryville, Md.19 (a) 3/1/48 (b) A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1948, at 11 A.M.p.d. by Dr. R. C. Dodson, D.M.E. 2-28-48

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☐, accident ☐, suicide ☐,homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Asphyxiation, due to suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Thomas J. Success M.D.Date signed 3/1/48 Medical Examiner.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age shown on:

ALM No. G 114 MAR 9 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01576 92

1. PLACE OF DEATH:

County Cecil
City or town Elkton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 4 hr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Cecil
City or town Rural near Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. 1, 7nd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Stens Korakas
4. Sex M. 5. Color or race Wh. 6. (a) Single, married, widowed, or divorced Single

3. (b) Social Security Number

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 10 - 1892
8. (c) If alive, give age years

8. AGE: Years 56 Months 5 Days 19 If less than one day hrs. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual occupation woodman

11. Industry or business

12. Name Korakas

13. Birthplace Greece

14. Maiden name Alamnow

15. Birthplace Greece

16. Informant Hospital Records

Address Elkton, Md

17. Burial Date thereof Mar 4/48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Md

18. Funeral director H. W. Lippin

Address Elkton, Md

19. Mar 3 19 48 JR Trazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 February 19 48 at 8:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 February 19 48 to 29 Feb 19 48 and that I last saw him alive on 28 February 19 48

Immediate cause of death

Septic myocarditis DURATION 2 1/2 hrs

Due to Biateral Solar Pneumonia 7 days

Due to CA

Other conditions Chronic nephritis Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

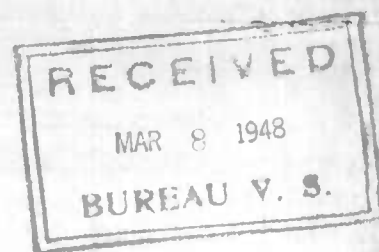
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature George J. Kreis, Jr. M.D.

23. SIGNATURE Elkton, Md M. D. or other 2-28-48

Address Elkton, Md Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

01577

1. PLACE OF DEATH:

County..... Cecil
 City or town..... Susquehanna River
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

WAS AWOL from VA Hospital, Perry Point, Md.
 since 2-18-48

How long in hospital or institution? 2 yrs. 1 mo. 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Pennsylvania County.....

City or town..... Philadelphia
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... 516 Kerper Street
 (If rural, give LOCATION)

2(a) If veteran, name war..... WW-II

3. (a) FULL NAME

MADDEN, John D.

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

white

Single

6. (b) Name of husband or wife..... --

7. Birth date of

deceased (mo., day, yr.) Dec. 23, 1924

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

23

1

25

.....hrs.min.

9. Birthplace..... Philadelphia, Pa.

(Town, county, and state)

10. Usual occupation..... Student

11. Industry or business..... --

12. Name..... Shirley Madden

13. Birthplace..... Unknown

14. Maiden name..... Mary Madden

15. Birthplace..... unknown

16. Informant..... Hospital records

Address VA Hospital, Perry Point, Md.

17. Removal Date thereof..... Apr. 5, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Unknown

Location..... Philadelphia, Pa.

18. Funeral director..... Pennington & Son
 Address Havre de Grace, Maryland

19. April 5, 1948 June S. daughter
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 2-18-48 at 1200

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him..... alive on.....19.....

Immediate cause of death.....

Drowned

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of 2-18-48

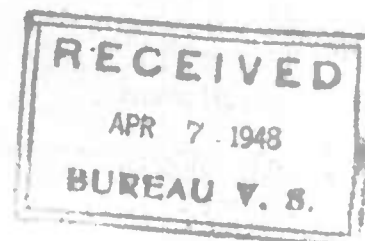
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, or other place..... Injured in street

Means of injury..... Injured at work?

23. Signature..... TIME
 Address..... Rising Sun, Md. M. D. or other

Date signed..... 4-4-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County..... Cecil

City or town..... Elton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, institution; or street address where death occurred:

106 Cecilton Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State..... Maryland County..... Frederick

City or town..... Brunswick
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary Elizabeth McBride

3. (b) Social Security Number

4. Sex..... female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... widowed

6. (b) Name of husband or wife..... Father E. McBride

deceased age 53

7. Birth date of..... 6. (c) If alive, give age..... years

deceased (mo., day, yr.)

8. AGE: July 5 - 1867

Years..... 180 Months..... 7 Days..... 8 It less than one day..... hrs. min.

9. Birthplace..... Burkittsville - Md

(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... George H. Tritapoe

13. Birthplace..... Virginia

14. Maiden name..... Madeline Castle -

15. Birthplace..... Maryland

16. Informant..... H. E. McBride (son)

Address..... Elton, Md

17. Burial Date thereof Feb 15 - 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Union Cemetery

Location..... Burkittsville, Md

18. Funeral director..... C. H. Fante + Bur.

Address..... Brunswick, Maryland

19. Feb 13 - 1948 J. H. Frazee

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 13 1948 at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 30 1947 to Feb 13 1948

and that I last saw him alive on Feb 12 1948

Immediate cause of death..... Myocardial

DURATION

2 weeks

Due to..... Cardio-vascular-renal disease unknown

Due to..... Cerebral thrombosis unknown

Other conditions..... from hypertension

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underlie the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... J. H. Frazee

M. D. or other

Address..... Elton - Md Date signed Feb 13/48

RECEIVED

FEB 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0157996

1. PLACE OF DEATH:

County Cecil
 City or town Port Deposit
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? About 38 Years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Cecil
 City or town Port Deposit
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 252 N. Main
 (If rural, give LOCATION)
 2. (a) If veteran, name war.

3. (a) FULL NAME

Lula Etta McMullen

3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>Colored</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>	
6. (b) Name of husband or wife <u>John Mc Mullen</u>			
6. (c) If alive, give age <u>68</u> years			
7. Birth date of deceased (mo., day, yr.) <u>June 9, 1885</u>			
8. AGE: Years <u>62</u>	Months <u>8</u>	Days <u>12</u>	If less than one dayhrs.min.
9. Birthplace <u>Worcester Co., Md.</u> (Town, county, and state)			
10. Usual occupation <u>House Wife</u>			
11. Industry or business			
FATHER	12. Name <u>Isaiah Johnson</u>		
	13. Birthplace <u>Md.</u>		
MOTHER	14. Maiden name <u>Rosina Waters</u>		
	15. Birthplace <u>Md.</u>		

16. Informant John Mc Mullen
 Address 252 N. Main St., Port Deposit, Md.

17. Burial Date thereof Feb. 24, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Unionville
 Location Pocomoke City, Md. Rural

18. Funeral director Lee A. Patterson & Son
 Address Perryville, Md.

19. Feb. 24, 48
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1948 at 2:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to Feb 21 1948
 and that I last saw h.e. alive on Feb 21 1948

Immediate cause of death Coronary Arteriosclerosis
& Possible Pulmonary Embolus
 Due to Chronic Myocarditis

DURATION

Four days
Over 2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Michael J. M.D.
 M. D. or other
 Address B. + D. St. + 11 Date signed 2-22-48

RECEIVED

FEB 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

96

01580

1. PLACE OF DEATH:

County..... **CECIL**
 City or town..... **PERRY POINT, MARYLAND**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **1 yr. 2 mos. 18 das.**
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.
 How long in hospital or institution? **Same as above**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **MARYLAND** County..... **Baltimore**
 City or town..... **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **1401 Webster Street**
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... **WW-I** ✓

3. (a) FULL NAME

MICHAEL R. NEWGIRG

3. (b) Social Security Number

4. Sex..... **Male** 5. Color or race..... **White** 6. (a) Single, married, widowed, or divorced..... **Married**
 8. (b) Name of husband or wife..... **Mrs. Lauretta E. Newgirk**
 8. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) **December 5, 1880**

8. AGE:	Years	Months	Days	If less than one day
	67	2	8hrs.min.

9. Birthplace..... **Illinois**
 (Town, county, and state)
 10. Usual occupation..... **Unknown**
 11. Industry or business.....
 12. Name..... **Henry Newgirk**
 13. Birthplace..... **Germany**
 14. Maiden name..... **Unknown**
 15. Birthplace..... **Germany**

16. Informant..... **Hospital Records**
 Address..... **VAH, Perry Point, Md.**
 17. **Removal** Date thereof..... **2-13-48**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematorium..... **New Cathedral Cemetery**
 Location..... **Baltimore, Maryland**
 18. Funeral director..... **WASHINGTON & SON**
 Address..... **HAVRE DE GRACE, MARYLAND**
 19. **Feb. 13, 1948** **J. E. Troller**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **February 13th** 19 **48** at **12:50 P.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **November 25th** 19 **46**, to **Feb. 13th** 19 **48**

and that I last saw him alive on..... 19.....

Immediate cause of death..... **Coronary Thrombosis** DURATION **1 1/2 days**

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... **None** Date of op.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE **A. E. Troller, M.D., Chf. Prof. Serv.**Address..... **VAH, Perry Point, Maryland** Date signed..... **2/13/48**

RECEIVED

FEB 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

520

01581

Reg. Dist. No. 96

1. PLACE OF DEATH:

County CECIL
 City or town PERRY POINT, MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years 9 mos. 28 das.
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Maryland
 How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MARYLAND County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1324 Harlem Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I

3. (a) FULL NAME

IRA NOEL

3. (b) Social Security Number

4. Sex M 5. Color or race N 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Josephine Noel
 7. Birth date of deceased (mo., day, yr.) October 15, 1887
 6.(c) If alive, give age _____ years
 8. AGE: Year 60 Months 3 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Unknown
 12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Hospital Records
 Address VAH, Perry Point, Md.
 17. Removal Date thereof February 11, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Unknown
 Location Lillian, Virginia
 18. Funeral director Burroughs & Son
 Address Havre de Grace, Maryland
 19. Feb 11 19 48 Irene E. Daugherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 19 48 at 7:40 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 22 19 46 to Feb. 9 19 48

and that I last saw him _____ alive on _____ 19 _____
 Immediate cause of death Bronchopneumonia DURATION 3 weeks
 Due to Carcinoma of the kidney 2 years
 Due to _____
 Other conditions Metastases to the lung and brain
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results No autopsy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE E. TROLLINGER, M.D., Chf., Prof. Serv. M. D. or other _____
VAH, Perry Point, Md. Address _____ Date signed 2/11/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01582

Reg. Dist. No.

94

1. PLACE OF DEATH:

County LeggillCity or town North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County LeggillCity or town North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edna Marie Pugh

3. (b) Social Security Number

4. Sex F5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Wm Nelson Pugh6. (c) If alive, give age 36 years7. Birth date of deceased (mo., day, year) Dec 3 19148. AGE: Years 33 Months 2 Days 13 If less than one day8. (b) Name of husband or wife Wm Nelson Pugh8. (c) If alive, give age 36 years9. Birthplace Hardegrave Md.

(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name David Hopkins13. Birthplace Hardegrave Md.14. Maiden name Mable Foythe15. Birthplace Wm Nelson Pugh16. Informant North East Md.

Address

17. Burial Date thereof Feb 18 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory North East Methodist CemeteryLocation North East Md.18. Funeral director Joseph R. GrantAddress North East Md.19. 2-18 1948 Lisa B. Owens

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1948 at 8:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death

Due to Gun shot woundDue to of left sideDue to under leftDue to breast

Other conditions

(Include pregnancy within 3 months of death)

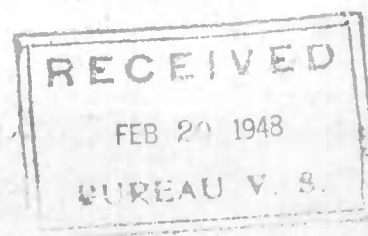
Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 2-16-48Where did injury occur North East Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury 12 Gauge shot gun Injured at work?23. SIGNATURE R. L. Dodson Medical ExaminerAddress Residing Gun Md. Date of 2-16-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01583

93d

Reg. Dist. No.

94

1. PLACE OF DEATH:

County Cecil
 City or town North East Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? lifetime
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Cecil
 City or town North East
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Alberta May Smith

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Floyd Smith

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 8 1878

8. AGE: Years 69 Months 9 Days 19 If less than one day _____ hrs. _____ min.

8. Birthplace North East (Rural) Cecil Co. Md
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business _____

12. Name John Lilly

13. Birthplace Md

14. Maiden name Radia Crumer

15. Birthplace Indiana

16. Informant Mrs. Mabel Diamond

Address North East, Md

17. Burial Date thereof March 7 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery - Methodist

Location North East, Md

18. Funeral director Joseph R. Grant

Address North East, Md -

19. March 2 48 Lidia V. Curran
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Feb 1948, at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1946 to 27 Feb. 1948

and that I last saw her alive on 27 Feb 1948

Immediate cause of death Cerebral Hemorrhage

Due to Cerebral Arteriosclerosis

Due to Hypertensive Arteriosclerotic Heart Disease

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

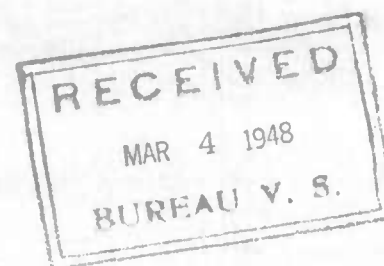
Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE Klaus H. Huchner M.D.

Address North East Md M. D. or other _____

Date signed 29 Feb 48



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH 01584

1. PLACE OF DEATH

County Cecil Registration Dist. No. 830
 Village or City Cecilton, Md. No. 90 St. Ward
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME HATTIE PAGE WALLACE If U. S. Veteran, specify WAR

(a) Residence: No. Cecilton Md. St. Ward.
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Col.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Charles R. Wallace</u>		
6. DATE OF BIRTH (month, day, and year) <u>Feb. 12, 1880</u>		
7. AGE Years <u>68</u>	Months <u> </u>	Days <u>17</u>
If LESS than 1 day, <u> </u> hrs. or <u> </u> min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as, SPINNER, SAWYER, BOOKKEEPER, etc. <u>Housewife</u>	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u> </u>	
	10. Date deceased last worked at this occupation (month and year) <u> </u>	
		11. Total time (years) spent in this occupation <u> </u>

12. BIRTHPLACE (city or town) Maryland
 (State or country)

13. NAME Fred Page
 14. BIRTHPLACE (city or town) Md.
 (State or country)

15. MAIDEN NAME Armenda
 16. BIRTHPLACE (city or town) Md.
 (State or country)

17. INFORMANT Charles R. Wallace
 (Address) 108 Delamore Place, Wilm. Del.

18. BURIAL, CREMATION, OR REMOVAL
 Place Cecilton Cem. Date 3/3/48, 19 48

19. UNDERTAKER Edw R Bell
 (Address) 909 Poplar St.

20. FILED Mar 3, 19 48 Mrs. Harvey W. Cheyney
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

February 29, 19 48
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from
January 30, 1947, to February 29, 1948

I last saw him alive on February 24, 1948; death is said
 to have occurred on the date stated above, at 12:45 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance
 were as follows:

Cerebral hemorrhage, 5 days
cerebral thrombosis

Other Contributory Causes of Importance:

gen. arterio sclerosis
Diabetes mellitus (under
control by diet)

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury , 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) John J. Papagachi M. D.

(Address) Esplanade, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01585 98

1. PLACE OF DEATH:

County Cecil
City or town White Crystal Beach Md. Eastville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 Yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town White Crystal Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Emma Jane Weir

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 15, 1864

6. (c) If alive, give age years

8. AGE:

83

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Kent Co. Md.
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Lumber P. Bouldin

12. Name

Md

13. Birthplace

14. Maiden name

Hannah Price

15. Birthplace

16. Informant

Mrs. Mary White Wright

Address

Bristol Eastville Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Bethel Cem.

Location

Bethel Md

18. Funeral director

Edward Fallow

Address

Millington Md

19.

(Date rec'd by registrar)

19

48

Mrs. Harold W. Chappay

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Feb 1948 at 2.00 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

9 Feb 1948 to 16 Feb 1948

and that I last saw him alive on 16 Feb 1948

Immediate cause of death

myocardial failure

DURATION

2 days

Due to

chronic myocarditis

Due to

Pneumonia, lobes
right lower lobe

7 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Allan R. Cuneally M.D.

M. D. or other

Address Millington, Del Date signed 18 Feb 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 20 1948

BUREAU V. S.

RECEIVED

FEB 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01586 91

1. PLACE OF DEATH:

County Cecil
 City or town Chesapeake City, B. D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil
 City or town Chesapeake City, B. D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Clifford Dodgson Whiteoak

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mary E. Whiteoak
 6. (c) If alive, give age 65 years
 7. Birth date of deceased (mo., day, yr.) Nor. 6 1877
 8. AGE: Years 70 Months 2 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Chesapeake City Md.
 (Town, county, and state)

10. Usual occupation Handling Contractor

11. Industry or business

12. Name George W. Whiteoak

13. Birthplace England

14. Maiden name Sarah Holmes

15. Birthplace England

16. Informant Mrs. Mary E. Whiteoak
 Address Chesapeake City, Md.

17. Burial Date thereof Feb. 5, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethel

Location near Chesapeake City, Md.

18. Funeral director H. Whiffin
 Address Elkton, Md.

19. February 5 19 48 Mrs. Ralph A. Bell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1948 at 4:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 22, 1946 to Feb. 2, 1948 and that I last saw him alive on Feb. 2, 1948

Immediate cause of death Heart Failure -

Due to Cardio-vascular - renal disease

Due to _____

Other conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Clifford W. Dodgson, M.D. M. D. or other
Elkton, Md. Address Date signed Feb. 3, 1948

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
FEB 6 1948
STEELE